IDAHO MEDICAID
STANDARD STATE PLAN

SECTION1. GENERAL OVERVIEW

1. A. ADMINISTRATIVE AUTHORITIES

The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)

The health benefits coverage available under the Standard State Plan provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under Title XIX of the Social Security Act. All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act.)

1. B. GEOGRAPHIC CLASSIFICATION

The Standard State Plan is in effect for all geographic and political subdivisions of the State.

1. C. SERVICE DELIVERY SYSTEM

Each individual enrolled in the Standard State Plan is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" under the authority of section 1932(a)(1)(A) of Social Security Act except in areas of the State where a choice of primary care providers enrolled in the program does not exist.

The payment method to the PCCM will be fee for service and a PMPM case management fee.

Mandatory Enrollment Exemptions.
The following eligibility groups are exempt from mandatory enrollment in the PCCM if they chose the Standard State Plan:

- Participants who are also eligible for Medicare
- Children under the age of 19 who are eligible for SSI
- Children under the age of 19 who are eligible under 1902(e)(3) of the Social Security Act
- Children under the age of 19 who are in foster care or other out of home placement
- Children under the age of 19 who are receiving foster care or adoption assistance under title IV-E

SECTION 2. COVERED POPULATIONS

2. A. COVERED INDIVIDUALS

The Idaho Medicaid Standard State Plan is available to the groups specified in this Section.

- AFDC Related Individuals
- Pregnant Women and infants under 1 year of age with family incomes up to 133% of the FPL
- Pregnant Women determined provider qualifies under presumptive eligibility criteria

- Low Income Children who meet Title XIX income guidelines
- Children up to 185% of the FPL under Title XXI

2. B. GENERAL CONDITIONS OF ELIGIBLITY

Each individual provided Medical Assistance under this State plan must meet the conditions of eligibility described 42 CFR Part 435 and Section 2 and applicable attachments to the Idaho State Plan.

Each individual provided Medical Assistance under this State Plan must meet the applicable non-financial eligibility conditions.

2. C. **APPLICATION PROCEDURES**

The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance.

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of available benefit options.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

To ensure that children are provided with the benefit package that will lead most directly to desired health outcomes, and to ensure that these benefits represent the most effective and efficient use of scarce health resources, Idaho Medicaid will incorporate a health risk assessment into Idaho's eligibility determination process and primary care case management (PCCM) program, Healthy Connections.
Applicants for medical assistance will complete an accompanying health questionnaire designed to assess general health status and health behaviors. The questionnaire will also serve as a screening tool to determine whether the applicant has special health needs. The Department will also assess whether the applicant requires special education services or is enrolled in Idaho's Children's Special Health Program, Infant and Toddler Program, Children's Mental Health Program or Adult Mental Health Program.

SECTION 3. COVERED SERVICES

3. A. GENERAL PROVISIONS

The Idaho Medicaid Standard State Plan is limited to services listed in section 1905(a)(1) through (5) and (21) of the Act, except for Nursing Facility in section 1905(a)(4)(A), is provided as defined in 42 CFR Part 440, Subpart A. See Section 3.L for special provisions under EPSDT.

3. B. **HOSPITAL SERVICES**

3. B.1 Inpatient Services

The Standard State Plan includes **Inpatient Hospital Services** permitted under sections 1905(a)(1) and 2110(a)(1) of the Social Security Act. These services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.

No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be Medically necessary as determined by the Department or its authorized agent.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Inpatient hospital services do not include those services provided in an institution for mental diseases.

Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

Limitations. The following service limitations apply to the Standard State Plan.

Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician.

Excluded Services. The following services are excluded from the Standard State Plan.

Elective medical and surgical treatments, except family planning services and medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department or its authorized agent.

New procedures of unproven value and established procedures of questionable current usefulness that are excluded by the Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.43.

Acupuncture, bio-feedback therapy, and laetrile therapy.

Procedures, counseling, and testing for the inducement of fertility.

Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21).

Treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded

from Medicaid, unless determined to be medically necessary by the Department or its designee.

All transplants

3. B.2 **Outpatient Services**

The Standard State Plan includes **Outpatient Hospital Services** permitted under sections 1905(a)(2) and 2110(a)(2) of the Social Security Act. These services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Limitations. The following outpatient services are not covered under the Standard State Plan.

- Physical Therapy
- Psychotherapy
- Occupational Therapy
- Speech Therapy

3. B.3 **Emergency Services**

The Standard State Plan includes **Emergency Hospital Services** provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this State plan. All obstetrical deliveries provided to aliens per Section 1903 (v) (3) of the Act are designated as emergency services.

Limitations. The following service limitations apply to the Standard State Plan.

Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be excluded from the above limitation.

The limit of six (6) emergency room visits will be waived for EPSDT recipients.

3. C. AMBULATORY SURICAL CENTER SERVICES

The Standard State Plan includes **Ambulatory Surgical Center Services** in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9), and 2110(a)(4) of the Social Security Act, including services provided under section 1905(a)(9).

Ambulatory surgical center services are outlined in applicable

Department rules and must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

3. D. PHYSICIAN SERVICES

3. D.1 Medical Services

The Standard State Plan includes **Physician Services** permitted under sections 1905(a)(5) and 2110(a)(4) of the Social Security Act. These services include office, clinic, out patient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

The Standard State Plan includes treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered.

Excluded Services:

Elective medical and surgical treatments, except family planning services without prior approval from the Department

New procedures of unproven value and established procedures of questionable current usefulness that are excluded from Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.443.

Non-medically necessary cosmetic surgery

Surgical procedures for the treatment of morbid obesity and panniculectomies unless medically necessary for co-morbid conditions.

Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy.

Procedures, counseling, office exams and testing for the inducement of fertility.

All transplants

Drugs

Treatment of complications, consequences, or repair of medical procedure in which the original procedure was excluded from Medicaid, unless determined to be medically necessary by the Department or its designee.

Hysterectomies that are not medically necessary and sterilization procedures for participants under age twenty-one (21).

Limitations:

Abortion Services. A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts.

When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.

Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health.

Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as a part of a vision exam). Individuals with Glaucoma are excluded from this limitation.

3. D.2 Medical and Surgical Services Furnished by a Dentist

The Department will reimburse for treatment of medical and surgical dental conditions by a licensed dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in IDAPA 16.03.09.800 and 16.03.10.80-85.

Dentist Limitations:

Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department.

All hospitalizations for dental care must be prior authorized by the Department.

Non medically necessary cosmetic services are excluded.

Drugs supplied to patients for self administration other than those allowed under IDAPA 16.03.09.611 - 666 are excluded.

3. E. **OTHER PRACTITIONER SERVICES**

The Standard State Plan includes the following **Other Practitioner Services** specified in sections 1905(a) (6) and 2110(a)(24) of the Social Security Act. These services include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Certified Pediatric or Family Nurse Practitioners' Services. Certified pediatric or family nurse practitioners' services are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law**.** This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a) (21) of the Act. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

Physician Assistant Services. Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Nurse-Midwife Services. Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

3. F. SCREENING SERVICES

3. F.1 **Well Child Screens.**

The Standard State Plan includes periodic medical screens completed at intervals recommended by the AAP, Committee in Practice and Ambulatory Medicine. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

3. F.2 Screening Services

Mammography Services. The Standard State Plan covers screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

3. G. **LABORATORY AND RADIOLOGICAL SERVICES**

The Standard State Plan includes **Laboratory and Radiological Services** permitted under sections 1905(a)(3) and 2110(a)(8) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

Excluded Services. The following services are excluded from the Standard State Plan.

Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.

3. H. **FAMILY PLANNING SERVICES**

The Standard State Plan includes **Family Planning Services** permitted under sections 1905(a)(4)(C) and 2110(a)(9) of the Social Security Act. These services include pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

Family planning services and supplies for individuals of

child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Standard State Plan covers diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

All requirements of 42 CFR Part 441, Subpart F are met.

Limitations. The following service limitations apply to the Standard State Plan covered under the State plan.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

3. I. HOME HEALTH CARE

The Standard State Plan includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), 2110(a)(14) and 2110(a)(15) of the Social Security Act when prior authorized by the Department.

These services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are provided in accordance with the requirements of 42 CFR 441.15.

3. J. ESSENTIAL PROVIDERS

3. J.1 **Rural Health Clinic Services**

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3. J.2 Federally Qualified Health Center Services

Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3. J.3 **Indian Health Services Facility Services**

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3. K. MEDICAL TRANSPORTATION SERVICES

The Standard State Plan includes Medical Transportation Services permitted under sections 1905 (as) (26), 1905 (a) (6) and 2110 (a) (17) of the Social Security Act.

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Limitations. The following service limitations apply to the Standard State Plan covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergent in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Standard State Plan is excluded.

3. L. SPECIAL SERVICES FOR CHILDREN/EPSDT

EPSDT Services. The Department meets the requirements of sections 1902(a)(43),1905(a)(4)(B), and 1905(r) of the Social Security Act with respect to early and periodic screening, and diagnostic, and treatment (EPSDT) services.

The Standard State Plan includes early and periodic screening, diagnostic and treatment services for individuals up to and including the month of their twenty-first (21st) birthday.

Screening: EPSDT services include the screening, immunization, vision, hearing and dental services recommended by the American Academy of Pediatrics periodicity schedule.

EPSDT services include diagnosis and treatment involving medical care within the scope of Idaho Standard State Plan and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Standard State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT.

Limitations:

The Department will not cover services for cosmetic, convenience or comfort reasons.

Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Standard State Plan will

be provided to individuals under the State plan without regard to amount, scope, and duration limitations, but will be subject to prior-authorization.

The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment.

3. M. **SPECIFIC PREGNANCY-RELATED SERVICES**

The Standard State Plan **Pregnancy-related services**, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

Pregnancy-related and postpartum services are provided for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

The State provides the full range of Medicaid Program services with limitations as elsewhere described in this State plan to eligible pregnant women if such service is related to a medical condition identified by the Department or its authorized agent as pregnancy related (either routine postpartum care, or arising from complications of pregnancy, including delivery).

1902(a)(47) and 1920 of the Act

For presumptively eligible pregnant women, ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under this State plan.

Ambulatory prenatal care for pregnant women is furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complications are covered services to pregnant women. Limitations as described elsewhere in this State plan are applicable.

1902(a)(10)(F)(VII) of the Act

Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.

3. N. LONG-TERM CARE SERVICES

3. T.1 Nursing Facility Services

The Standard State Plan includes **Nursing Facility Services** permitted under section 1905(a)(4)(A) of the Social Security Act. These services include nursing facility services (other than services in an institution for mental diseases) for individuals determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Limitations. The following service limitations apply to Medical Assistance covered under this State plan.

Skilled nursing facility services must have prior authorization before payment is made. For individuals age 21 and older, such prior authorization is initiated by the eligibility examiner who secures consultation from the regional inspection of care to review for a medical decision as to eligibility for nursing facility services and authorization of payment.

Nursing facility care services must have prior authorization before payment is made. For individuals under 21 years of age, such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to the eligibility for skilled nursing care services and authorization of payment.